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Implementation of the Declaration of Commitment on HIV/AIDS and the Political Declaration on HIV/AIDS

Declaration of Commitment on HIV/AIDS and Political Declaration on HIV/AIDS: midway to the Millennium Development Goals

Report of the Secretary-General

Executive summary

The present report reviews progress in implementing the 2001 Declaration of Commitment on HIV/AIDS and the 2006 Political Declaration on HIV/AIDS. Its findings are based primarily on the reports of 147 Member States on national progress in the response to HIV, which together represent the most comprehensive body of evidence ever assembled regarding the response to HIV in low-, middle- and high-income countries.[a] The present report has been prepared only two years before the target date the world set itself for achieving universal access to HIV prevention, treatment, care and support, and at the midway mark towards the target date of 2015 for achieving the Millennium Development Goals.

Since 2006, progress in the response to HIV is evident in many regions, reflecting a return on the substantial investments made to date. However, progress is uneven and the expansion of the epidemic itself is often outstripping the pace at which services are being brought to scale. In 2007, the number of new HIV infections was 2.5 times higher than the increase in the number of people receiving antiretrovirals, underscoring the pressing need for a stronger commitment to HIV prevention. Unless greater and swifter advances are made in reaching those who need essential services, the epidemic's burden on households, communities and societies will continue to mount.

[a] For full analysis of specific country indicators data, see *2008 Report on the Global AIDS Epidemic* (United Nations publication, forthcoming (August 2008)); meanwhile, country progress reports may be consulted on the UNAIDS website at http://www.unaids.org/en/KnowledgeCentre/HIVData/CountryProgress/2007CountryProgress.asp.

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Key findings

Status of the epidemic

As of December 2007, an estimated 33.2 million people[b] worldwide were living with HIV. In 2007, an estimated 2.5 million people were newly infected with HIV and 2.1 million AIDS deaths occurred.

Young people's HIV knowledge

In 2007, national surveys found that 40 per cent of young males (ages 15-24) and 36 per cent of young females had accurate knowledge regarding HIV — still well below the 95 per cent goal for young people's HIV knowledge unanimously endorsed by Member States in the Declaration of Commitment on HIV/AIDS.

Prevention of mother-to-child transmission

The percentage of HIV-infected pregnant women receiving antiretrovirals to prevent mother-to-child transmission increased from 14 per cent in 2005 to 34 per cent in 2007.

HIV prevention for populations most at risk

Globally, most injecting drug users and men who have sex with men lack meaningful access to HIV-prevention services. Sex workers are somewhat more likely to receive HIV-prevention services, although access is sharply limited in many countries.

Women and HIV

More than 80 per cent of countries, including 85 per cent in sub-Saharan Africa, have policies in place to ensure the equal access of women to HIV prevention, treatment, care and support. Women in sub-Saharan Africa have equal or greater access to antiretrovirals, but the reverse is true for women in concentrated epidemics. Although most countries have strategic frameworks that address the epidemic's burden on women, only 53 per cent provide budgeted support for women-focused programmes.

HIV treatment

Antiretroviral coverage rose by 42 per cent in 2007, reaching 3 million people in low-income and middle-income countries, approximately 30 per cent of those in need. Despite the existence of affordable treatments for tuberculosis (TB), only 31 per cent of individuals living with HIV and TB co-infection received both antiretroviral and anti-TB drugs in 2007.

Children orphaned or made vulnerable by HIV

According to recent household surveys conducted in 11 high-prevalence countries, an estimated 15 per cent of orphans live in households receiving some form of assistance, a modest increase over the estimated 10 per cent reported by high-prevalence countries in 2005.

[b] Range: 30.6 to 36.1 million people.

Discrimination and stigma

Although the number of countries with laws to protect people living with HIV from discrimination has increased since 2003, one third of countries still lack such legal protections. While 74 per cent of countries have policies in place to ensure equal access to HIV-related services for vulnerable groups, 57 per cent of these have laws or policies that impede access to HIV services.

Financing

Funding for HIV-related activities in low-income and middle-income countries reached US$ 10 billion in 2007 — a 12 per cent increase over 2006 and a tenfold increase in less than a decade. In low-income and lower middle-income countries, per capita domestic spending on HIV more than doubled between 2005 and 2007.

Key recommendations

National leadership

Although nearly all countries have national policies on HIV, most have not been fully implemented and key components of national strategies often lack any budgetary allocation. Senior political leaders in countries, with the assistance of donors, technical agencies and civil society, should vigorously lead the process to ensure the implementations of policies on HIV.

Sustainability of the response to HIV

National leaders and Governments, donors, researchers, non-governmental organizations and all other stakeholders engaged in the response to HIV must begin planning for the long term, building into their efforts strategies to ensure the sustainability of the robust, adaptable and enduring collective effort that will be required over generations.

Scaling up HIV prevention in hyper-endemic countries

In countries where HIV prevalence exceeds 15 per cent, only an unprecedented national mobilization, involving every sector of society and making use of every available prevention tool, will meet the challenge posed by such catastrophic continued spread of HIV.

Mounting an effective response in concentrated epidemics

Even in countries with low levels of HIV infection, populations most at risk are experiencing an exceptionally heavy burden of disease, including substantial numbers of new HIV infections. Scaling up focused HIV-prevention strategies for populations most at risk represents an urgent public health imperative, requiring a degree of political courage and leadership that has often been lacking.

Sustaining HIV treatment scale-up while strengthening measures to address HIV/TB co-infection

While continuing and strengthening efforts to achieve universal access to HIV treatment, including antiretrovirals, countries should urgently undertake initiatives to improve prevention, diagnosis and treatment of TB in HIV-positive individuals and to diagnose HIV infection in those with TB.

Addressing the role of gender inequities in the HIV epidemic

Countries should ensure a massive political and social mobilization to address gender inequities, sexual norms and their roles in increasing HIV risk and vulnerability.

I. Introduction

1. Since 2006, progress in containing the HIV epidemic is now being seen in nearly all regions of the world. In some of the world's most resource-constrained settings, life-preserving HIV treatments are being scaled up and changes in sexual behaviours are reducing the number of new HIV infections.

2. The world is starting to reap the benefits of the unprecedented investments made during the present decade in responding to the HIV epidemic. The encouraging results reported in many regions demonstrate what can be achieved when there is global resolve, political commitment and the active engagement of people living with HIV and affected communities.

3. Yet these positive trends are not uniform across or even within countries. New infections continue to increase in several countries, while coverage for essential HIV prevention, treatment, care and support remains far too low in many parts of the world to have a major impact on the course of the epidemic. Especially in the countries most heavily affected by HIV, the epidemic's impact continues to grow, with increasing numbers of HIV-affected households and children orphaned or made vulnerable by HIV. Moreover, recent progress cannot obscure the epidemic's continuing human toll, including the deaths of an estimated 25 million people from AIDS since the start of the epidemic.

4. The rate of progress in expanding access to essential services is failing to keep pace with the expansion of the epidemic itself, a shortcoming that is especially evident with respect to HIV prevention. While an additional 1 million people were started on antiretrovirals in 2007, 2.5 million people were newly infected. Unless the international community takes immediate action to follow through on the pledges made to implement an exceptional response to HIV, the epidemic's humanitarian and economic toll will continue to increase.

II. A time to assess progress

5. Following the establishment of the Millennium Development Goals in 2000, Member States made the commitment to work towards a world that is safer, healthier and more equitable. In 2001, Member States unanimously embraced a series of time-bound targets in the Declaration of Commitment on HIV/AIDS (General Assembly resolution S-26/2, annex). In the 2006 Political Declaration on HIV/AIDS (General Assembly resolution 60/262, annex), Member States restated their commitment to achieve the time-bound targets agreed on in 2001 and to move towards universal access to HIV prevention, treatment, care and support by 2010.

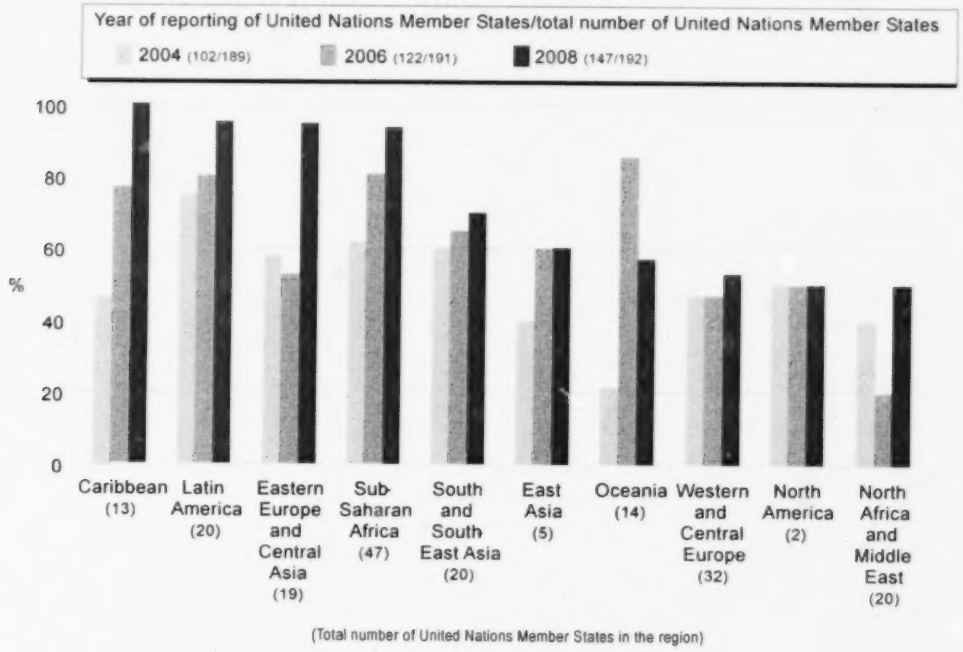
6. The response to the HIV epidemic, while specifically linked to Millennium Development Goal 6 on reducing the burden of the epidemic, also supports the achievement of most of the other Goals. For example, mitigating the epidemic's impact will advance Goal 1, which aims to eradicate extreme poverty and hunger, and the response to HIV also helps to empower women and promote gender equality (Goal 3). With more than half of all HIV-infected infants dying before age two, the prevention of mother-to-child HIV transmission and the provision of paediatric HIV treatment together support progress towards Goal 4, to reduce child mortality. The response to HIV also supports the push towards universal primary education, in support of Goal 2, and is helping drive increased innovation and global partnerships

for development (Goal 8). Thus, progress towards reversing the HIV epidemic is central to the broad international development agenda.

7. Since it is only two years before the deadline for universal access to HIV prevention, treatment, care and support, and midway towards the target date of 2015 for achieving the Millennium Development Goals, the present report assesses progress to date in the global response to HIV. As of 10 March 2008, 147 Member States had reported national information against 25 core indicators that were developed to track implementation of the 2001 Declaration of Commitment on HIV/AIDS. The core indicators cover a broad array of variables, such as HIV prevalence among young people aged 15-24; coverage of antiretroviral therapy and key HIV prevention interventions; services to support children orphaned or made vulnerable by HIV; and national adoption of recommended HIV policies. Information from national progress reports has been supplemented by information from other data sources, such as household surveys; civil society reports; and the budgets and programme-monitoring data of donor Governments, the co-sponsors of the Joint United Nations Programme on HIV/AIDS (UNAIDS), philanthropic foundations and research agencies. Further information on the HIV-related work of UNAIDS co-sponsors is provided in the annex.

8. The number of countries reporting on core indicators of national progress has steadily increased in recent years (figure 1).

Figure 1
Percentage of United Nations Member States reporting, by region, 2004-2008

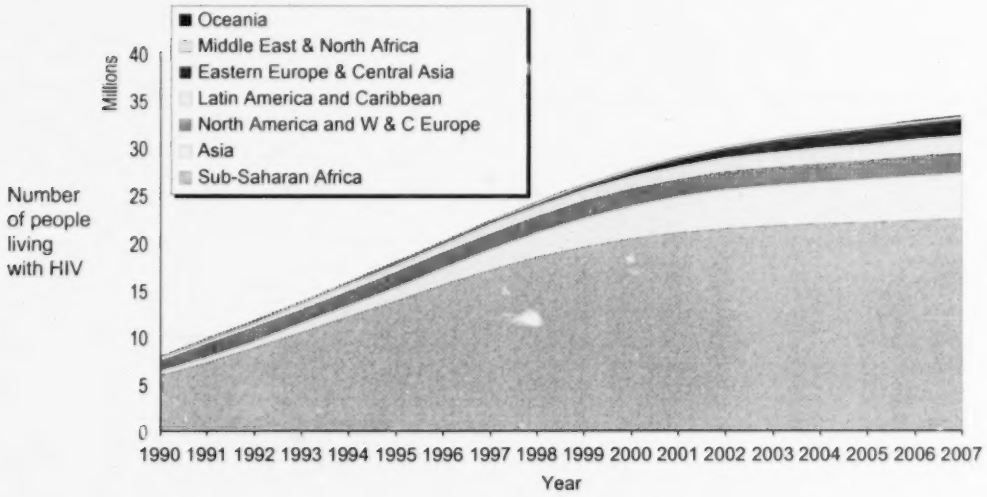


9. In nearly all countries, civil society groups were actively involved in the monitoring and reporting of progress on the core indicators for the Declaration of Commitment on HIV/AIDS. They have provided data to supplement national reports, have engaged in national reporting workshops and produced shadow reports. In 75 per cent of countries, civil society groups reported that their involvement in the national response to HIV improved between 2005 and 2007, although they indicated that such engagement remains inadequate in nearly one quarter of countries.

III. Status of the HIV epidemic

10. Estimates of the magnitude and trajectory of the epidemic have improved due to an increasing number of national household surveys, expanded surveillance programmes and improved modelling methods. The most recent data include some encouraging news, although the breadth and severity of the epidemic remain unmatched in modern times by any other infectious disease. An estimated 33.2 million people[1] worldwide were living with HIV as of December 2007 (figure 2). The annual rate of new HIV infections appears to have decreased over the last decade, with an estimated 2.5 million people newly infected with HIV in 2007 — down from 3.2 million in 1998. The annual number of AIDS deaths has declined from 3.9 million in 2001 to 2.1 million in 2007, in part as a result of the substantial increase in access to HIV treatment in recent years. Worldwide, women represent half of all HIV infections among adults, but 61 per cent of those infected in sub-Saharan Africa.

Figure 2
Estimated number of adults and children living with HIV, by region, 1990-2007



[1] Range: 30.6 to 36.1 million people.

11. Sub-Saharan Africa accounted for 68 per cent of all adults living with HIV, 90 per cent of the world's HIV-infected children and 76 per cent of all AIDS deaths in 2007. Although different countries have diverse epidemics, AIDS remains the leading cause of death in the region. According to national estimates that incorporate sentinel surveillance and population-based sero-prevalence surveys, the percentage of adults aged 15-49 and living with HIV ranges from 0.7 per cent in Senegal to 25.9 per cent in Swaziland. In many countries, especially outside sub-Saharan Africa, low levels of infection in the general adult population masks higher infection levels among populations most at risk, including sex workers, injecting drug users and men who have sex with men. In Asia, where the percentage of the population living with HIV is much lower than in sub-Saharan Africa, a recent report indicated that AIDS remains the leading cause of death from disease among people aged 15-44.

12. Expanded sets of data and new methods of analysis indicate that although the rate of new infections has fallen globally, the number of people newly infected has increased in a number of countries. These include China, Indonesia, the Russian Federation and Ukraine, while HIV infections also seem to be increasing in European Union countries and North America. The number of new infections has yet to fall in some of the most heavily affected countries, such as Lesotho, Swaziland and South Africa. Moreover, even where infection levels have stabilized or declined, the dimensions of the epidemic remain alarming. Especially in sub-Saharan Africa, HIV remains a humanitarian crisis and one of the greatest threats to development.

13. The number of patients needing therapy continues to outstrip available financial, human and logistical resources. The future viability of HIV treatment programmes could be in jeopardy. Every effort is needed to sharply reduce new HIV infections.

IV. Status of the response to the HIV epidemic

14. Substantial progress has been made in scaling up essential HIV prevention, treatment, care and support services for those who need them. Financial resources for a multisectoral HIV response continue to increase, and many countries are putting in place policies and programmes required to mount an evidence-informed response to the epidemic.

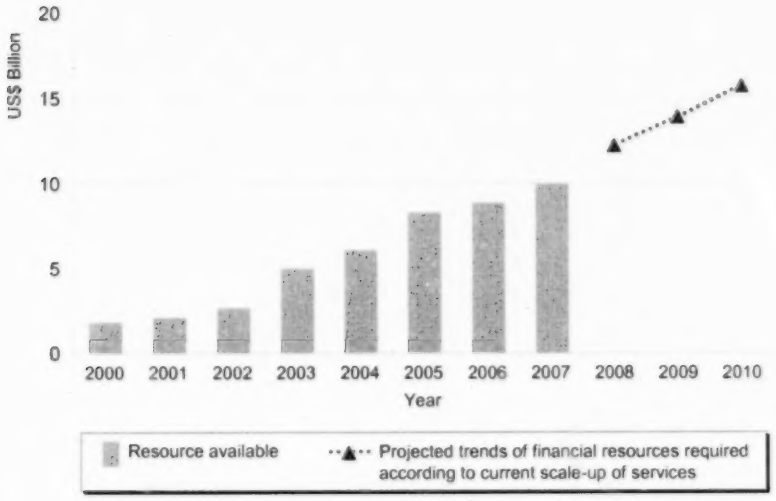
15. Yet few countries have effectively brought to scale the broad range of strategies needed to support a comprehensive effort against the epidemic. Certain critical services, such as support for children orphaned by the epidemic, are not expanding as quickly as others. Moreover, some countries that reported early success against the epidemic are having difficulty sustaining previous achievements. For example, in Uganda, where an early commitment to a robust response to HIV led to widespread behaviour change and sharply lower rates of new HIV infections, recent surveys have revealed increases in risk behaviours and a decline in knowledge about HIV among young people.

16. While the resources mobilized to date are impressive, the gap between available resources and actual needs is increasing annually. Current trends suggest that the world will fall short of achieving universal access to HIV prevention, treatment, care and support services, without a significant increase in the level of

resources available for HIV programmes in low- and middle-income countries. Figure 3 presents the minimum estimated financial resources needed just to continue the current rate of scale-up of services.

Figure 3
Total annual resources available for HIV prevention, treatment, care and support from 2000 to 2007, and projected trends of resources required according to current scale-up of services for 2008 to 2010

(Billions of United States dollars)



A. National readiness

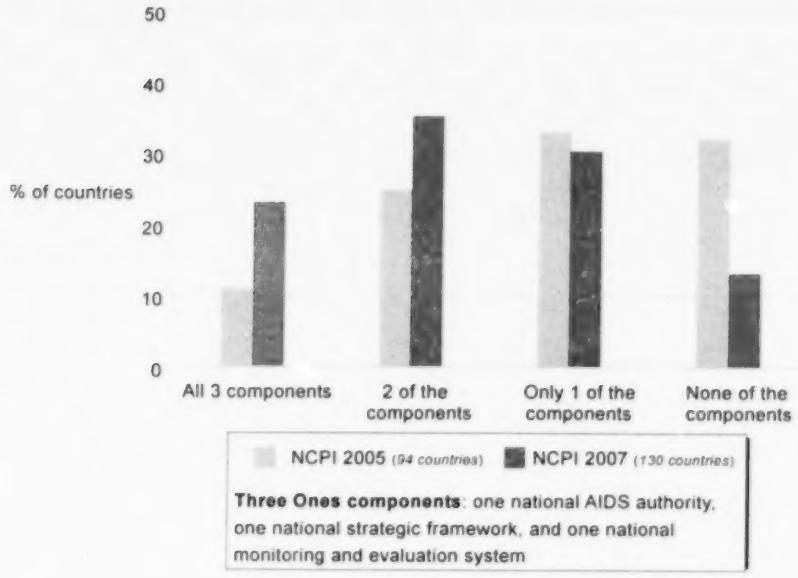
17. The actions that countries must take to plan and implement effective national responses to HIV are well defined. Countries should have in place multisectoral, costed and prioritized strategies and action plans guided by solid evidence regarding their national epidemic, as well as comprehensive policies to support effective action against HIV.

18. Frameworks for effective national responses are in place in most countries: 97 per cent of countries have a multisectoral HIV strategy, 92 per cent have a national HIV coordinating body, 92 per cent have a national monitoring and evaluation plan in place or in development, and all low- and middle-income countries have integrated HIV into national development plans. In 69 per cent of countries, national HIV frameworks have been translated into costed operational plans with identified funding sources.

19. To improve the harmonization and alignment of international development aid with country-owned strategies and plans, the "Three Ones" are being promoted in countries — one national AIDS authority, one national strategic framework, and one national monitoring and evaluation system. Countries have made steady progress in

implementing the Three Ones (figure 4), although the quality of their implementation needs to improve in many countries.

Figure 4
Country progress in improving the implementation quality of the Three Ones: one national AIDS authority, one national strategic framework and one national monitoring and evaluation system



20. According to Government reports, 83 per cent of national HIV coordinating bodies include civil society representatives. Reports of civil society groups indicate that they have been involved in the review of national HIV strategies in 84 per cent of countries and in national planning and budgeting in 59 per cent of countries. However, civil society groups have access to adequate financial support in only 19 per cent of countries.

21. While national readiness to address HIV has improved, many national frameworks have not been effectively implemented. For example, although nearly all countries have national strategic frameworks addressing populations most at risk, fewer than half have implemented HIV prevention services focused on injecting drug users, men who have sex with men or sex workers in all or most districts in need.

B. HIV prevention

22. The 2001 Declaration of Commitment on HIV/AIDS recognized HIV prevention as the "mainstay of the response". Member States committed to implement comprehensive, evidence-informed strategies to reduce the number of people newly infected with HIV and to support targeted programmes to prevent HIV

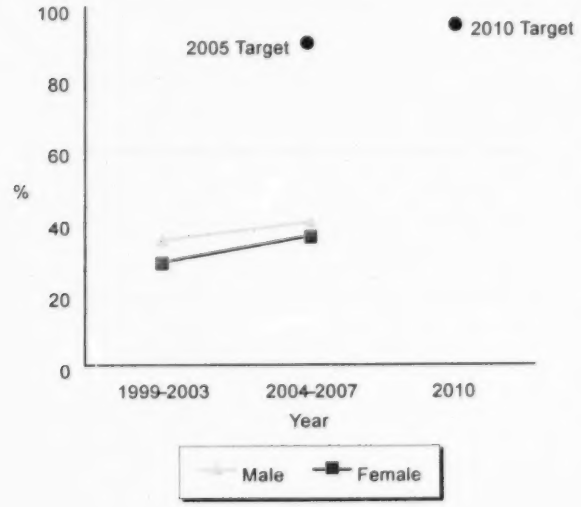
transmission in the vulnerable populations most heavily affected by the epidemic. The 2006 Political Declaration on HIV/AIDS pledged action at the global, regional and national levels to ensure universal access to life-saving HIV prevention measures.

23. As part of the 2001 Declaration of Commitment, Member States made a commitment to reduce the number of HIV infections among young people by 25 per cent by 2010. To assess progress towards that goal, countries reported data from sero-prevalence surveys of young women in antenatal clinics. In 12 high-prevalence countries[2] with sufficient data to identify trends, HIV prevalence among young women has declined since 2000-2001, in some cases by more than 25 per cent, with more modest reductions elsewhere. However, no decrease in HIV prevalence among young people has been observed in Mozambique, South Africa and Zambia.

1. Increasing young people's knowledge

24. Member States pledged to ensure that 95 per cent of young people aged 15 to 24 have accurate and complete knowledge of HIV by 2010. In 2007, national surveys found that 40 per cent of young men and 36 per cent of young women had accurate knowledge of HIV, as measured by surveys based on five HIV-related questions (figure 5). Although these figures show a trend towards improved knowledge levels seen earlier this decade, such rates remain far below those envisioned in the 2001 Declaration of Commitment. Both in sub-Saharan Africa and globally, young women had lower levels of basic HIV knowledge than males. Most young people know that condoms can prevent sexual transmission, and 80 per cent of young men and women are aware that being in a monogamous relationship with a person of the same sero-status is an effective prevention strategy.

Figure 5
Comprehensive knowledge of HIV among young people aged 15-24, 1995-2005



[2] Including the Bahamas, Botswana, Burkina Faso, Burundi, Côte d'Ivoire, Kenya, Malawi, Namibia, Rwanda, Swaziland, the United Republic of Tanzania and Zimbabwe.

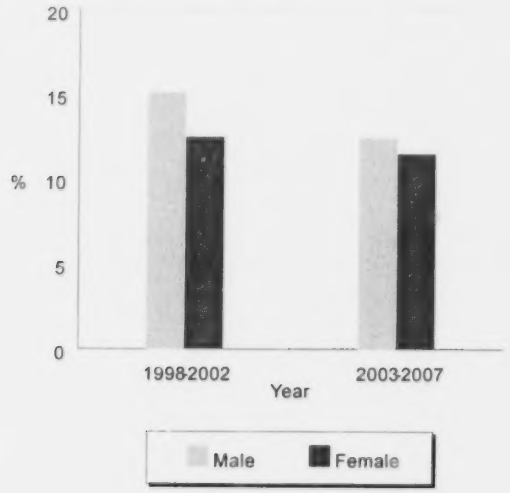
25. In countries with generalized epidemics, fewer than 70 per cent have implemented school-based HIV education in most or all districts, and 61 per cent have put in place HIV prevention programmes for out-of-school youth. Where programmes exist, their quality has often not been evaluated.

2. Reducing sexual transmission of HIV

26. In recent years, data from selected countries, such as Kenya and Zimbabwe, indicate that significant, population-wide changes in sexual behaviour can be achieved and that such behavioural shifts have the potential to reverse national epidemics.

27. In low- and middle-income countries, the percentage of young people having sex before age 15 is decreasing in all regions — a continuation of trends detected earlier this decade (figure 6). Between 1998 and 2007, the share of young people globally reporting sexual intercourse before age 15 fell from 14 per cent to 12 per cent. Worldwide, boys are significantly more likely to report sex prior to age 15 except in sub-Saharan Africa, where adolescent girls under 15 are almost 50 per cent more likely than boys to be sexually active. While global trends towards delayed sexual debut are clear, surveys reveal substantial variations between countries, including a trend towards earlier sexual debut in some countries. Globally, 15 per cent of adult men aged 15-49 reported having sex with more than one partner in the previous 12 months, compared to 6 per cent of women.

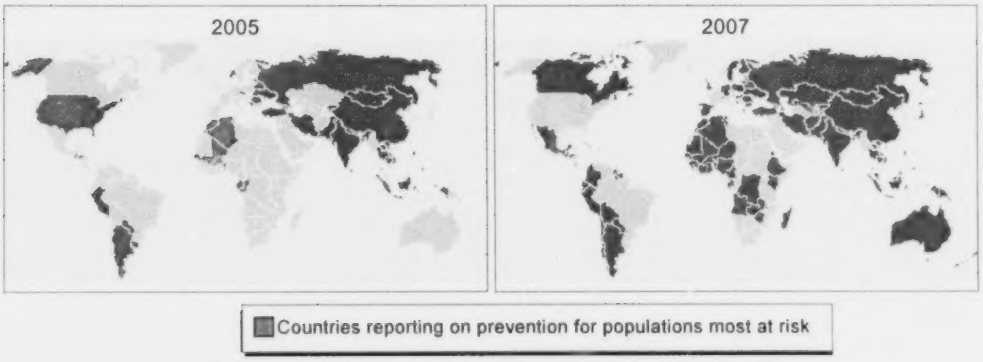
Figure 6
Percentage of young people who have first sex before age 15, by gender



3. HIV prevention for populations most at risk

28. In diverse countries across the world, certain groups are at especially high risk of HIV exposure, including injecting drug users, men who have sex with men and sex workers.

Figure 7
Countries reporting in 2005 and 2007 on prevention services for populations most at risk



29. As figure 7 illustrates, an increasing number of countries are reporting on the HIV-related needs of populations at greatest risk, a possible reflection of the growing awareness of the importance of such groups in the national response. However, most countries have yet to implement focused prevention programmes for populations most at risk. For example, only 34 per cent of countries with a concentrated or low epidemic have implemented programmes to reduce risk among injecting drug users. In 17 countries reporting, 46 per cent of injecting drug users reported knowing where they could receive an HIV test and be provided with condoms and sterile injecting equipment. Regionally, prevention coverage for injecting drug users is highest in South and South-East Asia, at 62 per cent. Thus, while countries like Indonesia are developing comprehensive harm reduction programmes for injecting drug users, access to key components of harm reduction remains limited in other countries, including many Eastern European and Central Asian countries.

30. Thirty-nine per cent of countries with concentrated or low epidemics have implemented HIV risk reduction programmes for men who have sex with men in all or most districts in need. Forty per cent of men who have sex with men surveyed in 28 countries say they are aware of how to obtain a condom or where they may be tested for HIV. In several countries — including Armenia, Greece, Mexico, Papua New Guinea and Turkey — fewer than 25 per cent of men who have sex with men have access to condoms. Greater national commitment is urgently needed to strengthen prevention efforts for men who have sex with men, such as that recently shown by Brazil, which in 2008 launched a national media initiative to promote risk reduction among young men who have sex with men.

31. In general, sex workers are more likely than men who have sex with men to have access to HIV prevention services. Sixty-one per cent of countries with generalized epidemics say that prevention services for sex workers have been implemented in all or most districts. Globally, 60 per cent of sex workers worldwide reported having access to HIV testing and condoms, although in several countries condom access is limited to fewer than half of those who need them.

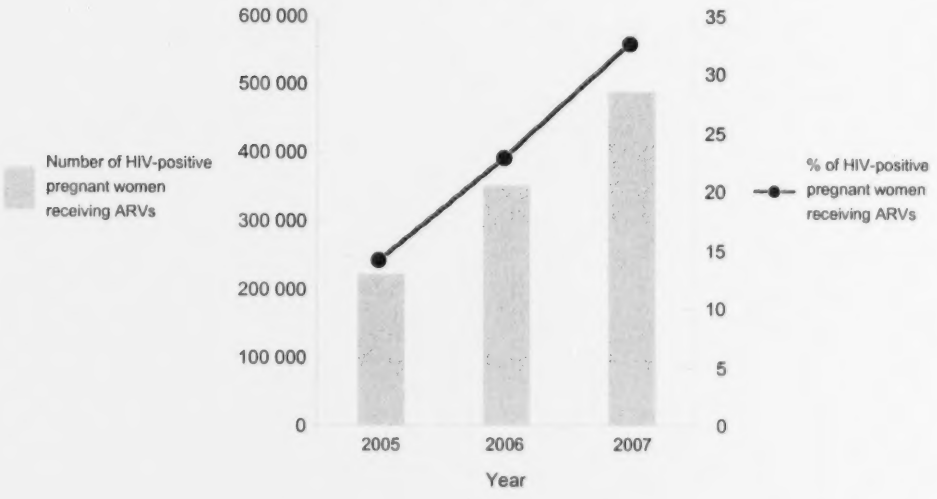
4. Preventing mother-to-child transmission

32. Although the cost-effectiveness of mother-to-child HIV transmission prevention programmes was demonstrated in the 1990s, children still accounted for one in six new HIV infections in 2007. The vast majority of those infections occurred during pregnancy or delivery or as a result of breastfeeding. The majority of children infected perinatally die before the age of two.

33. High-income countries have virtually eliminated the risk of mother-to-child HIV transmission through the implementation of comprehensive prevention measures, including primary prevention of HIV infection; fewer unintended pregnancies among HIV-positive women; provider-initiated HIV testing and counselling in antenatal settings; timely delivery of antiretroviral prophylactic regimens; and safe infant-feeding. In the 2001 Declaration of Commitment on HIV/AIDS, countries pledged to ensure that 80 per cent of pregnant women who have access to antenatal care are offered HIV prevention services. Based on revised epidemiological estimates, global coverage for prevention of mother-to-child transmission increased from 14 per cent in 2005 to 34 per cent in 2007 (figure 8).

34. However, there are notable exceptions to global averages, such as the Bahamas, Botswana and Thailand, where coverage in 2007 reached as high as 80 per cent, demonstrating that reaching universal access at the country level is indeed possible. In Botswana, where the Government made prevention of mother-to-child transmission a national priority, the country reduced the infection rate for children born to HIV-infected mothers in 2007 to 4 per cent, demonstrating the feasibility and impact of such programmes in resource-limited settings.

Figure 8
Number and percentage of HIV-positive pregnant women receiving antiretrovirals, 2005-2007



35. This progress demonstrates the potential to make mother-to-child HIV transmission a rare event even in resource-limited settings. Building on recent successes, Governments, donors and other stakeholders should redouble efforts to expand access to services to prevent mother-to-child transmission, making special efforts to extend such services to both rural areas and urban settings.

5. The search for new technologies to prevent HIV transmission

36. Since the release of results from clinical trials on adult male circumcision,[3] which reinforced the findings of observational studies that circumcision reduces the risk of female-to-male sexual transmission by approximately 60 per cent, many countries are now introducing or scaling up circumcision programmes. Studies are ongoing to determine whether adult male circumcision confers a direct prevention benefit to female partners and for men who have sex with men.

37. Results from trials of other potential HIV prevention approaches have yielded more sobering findings. Studies of the most promising HIV vaccine candidate were halted in September 2007 owing to the vaccine's lack of efficacy. Studies of early-generation microbicides have similarly failed to detect a prevention benefit, and disappointing results were reported on the HIV prevention potential of female diaphragms and community-based acyclovir treatment for herpes simplex virus type 2. But despite finding a lack of efficacy, those trials were useful in informing future research directions. In the case of microbicides, for example, work is already

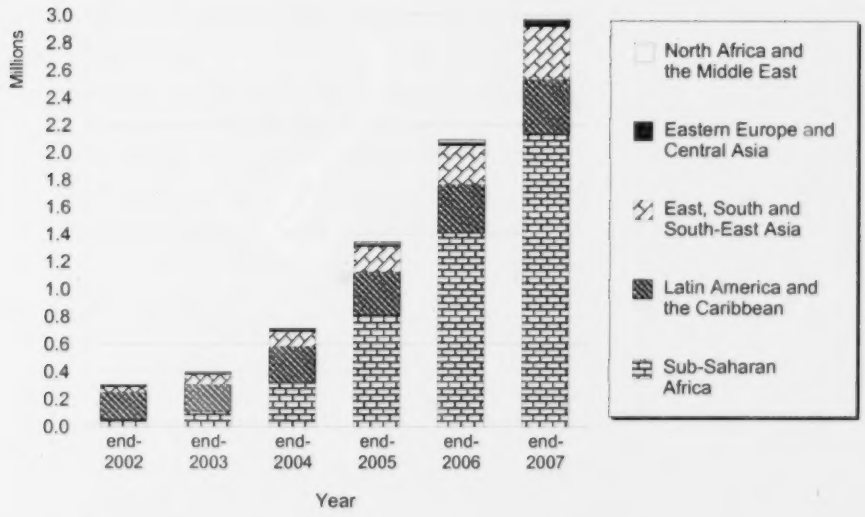
[3] Clinical trials were held in South Africa, Kenya and Uganda.

under way on the next generation of candidates, including gels with an antiretroviral drug to be applied topically. Research continues on other experimental methods, such as pre-exposure antiretroviral prophylaxis. The likelihood that the time horizon for major new biomedical prevention breakthroughs may be lengthy further underscores the importance of making maximum use of the effective prevention strategies that are currently available.

C. HIV treatment and care

38. By the end of 2007, an estimated 3 million people in low- and middle-income countries were receiving antiretrovirals — a 42 per cent increase over December 2006 and a tenfold rise over the last five years. Globally, almost 30 per cent of those who were estimated to need antiretrovirals in 2007 were receiving these drugs (figure 9).

Figure 9
Number of people receiving antiretrovirals in low- and middle-income countries, 2002-2007



39. Increases in treatment access have been extraordinary in many countries. For example, in Namibia, where treatment coverage was negligible in 2003, 88 per cent of individuals in need were on antiretrovirals in 2007. In Rwanda, antiretroviral coverage increased from 1 per cent in 2003 to almost 60 per cent in 2007. In Thailand and Viet Nam, treatment coverage increased more than tenfold between 2003 and 2007.

40. Worldwide, gender parity seems to exist in terms of coverage with antiretrovirals. In a number of countries with generalized epidemics, however, coverage is significantly higher among females. By contrast, women in need are

significantly less likely to be on antiretrovirals in several countries with concentrated epidemics.

41. Notwithstanding the considerable achievements in expanding access to life-preserving HIV treatments, substantially greater progress will be required to achieve universal access to HIV treatment and care. If the current trajectory of treatment scale-up continues, 4.6 million people in need will be on antiretrovirals in 2010 and 8 million in 2015. Those figures fall short of projected need; in 2007, an estimated 9.8 million people living with HIV were medically eligible to be put on antiretrovirals, and that number is certain to rise as the disease progresses among the more than 33 million people currently living with HIV.

42. Owing to advocacy by activists, UNAIDS and other partners, the emergence of competition from generic manufacturers and significant price cuts by pharmaceutical companies,[4] prices for many first-line antiretrovirals have fallen sharply over the last decade. International intellectual property agreements have also helped facilitate improved access to life-preserving medications for people living with HIV. Yet further price reductions for antiretrovirals will be needed to ensure the sustainability of treatment programmes, especially with respect to newer antiretrovirals and drugs for second- and third-line therapy, most of which are currently more expensive than standard first-line regimens. Prices for antiretrovirals are not immutable, as demonstrated when the Clinton Foundation and UNITAID in May 2007 announced steep price cuts for 16 different regimens based on eight second-line antiretrovirals.

43. Despite significant gains in life expectancy for people living with HIV since treatment scale-up began, people on antiretrovirals in lower-income countries still have higher mortality than their counterparts in high-income settings. A greater prevalence of other undiagnosed illnesses and differential access to health care are thought to contribute to those unequal medical outcomes. Furthermore, early losses to follow-up in antiretroviral programmes are becoming increasingly common as antiretroviral services are scaled up, and are associated with fee-for-service programmes and more advanced immune suppression when initiating antiretrovirals.

1. The special plight of children living with HIV

44. Children living with HIV are significantly less likely to receive antiretrovirals than HIV-positive adults in sub-Saharan Africa. Disparities in coverage between adults and children are especially pronounced in West Africa.

45. Diagnosis of HIV infection is more difficult in infants than in adults, and the adult medicines used as standard treatment are inappropriate for younger children. Fortunately, reliable diagnostic tests for HIV infection in infants have become less expensive and are now being used at remote sites. User-friendly tools have been developed to aid clinicians in administering proper doses of antiretrovirals in children, and formulations of medicines designed for children are also becoming available. Concerted action is now needed to scale up access to those tools and medications throughout the world to ensure that children have equal access to HIV treatment.

[4] For example, the average annual price of lopinavir/ritonavir combination for middle-income countries decreased from US$ 4,510 in 2004 to US$ 1,137 in 2007; over the same time period, the price of tenofavir decreased from US$ 279 to US$ 225.

2. HIV co-infections and the need for dual treatment

46. Tuberculosis remains one of the leading causes of death among people living with HIV, with sub-Saharan Africa alone accounting for 85 per cent of cases of people living with HIV and TB. Yet only 31 per cent of people living with HIV and TB worldwide and 34 per cent in sub-Saharan Africa received both antiretroviral and anti-TB therapies in 2007.

47. Of the 63 countries that account for 97 per cent of estimated cases of TB in people living with HIV, 63 per cent have established national plans that integrate HIV and TB programmes. However, actual programme utilization data demonstrate that many such plans have not been effectively implemented. Although the Global Plan to Stop TB 2006-2015 set a global target of testing 1.6 million TB patients for HIV in 2006, only 706,000 were actually tested for HIV in 2006. Similarly, 42 per cent of countries with generalized HIV epidemics have implemented routine TB screening for people living with HIV, but only 27 per cent provide TB preventive therapy in all districts for people living with HIV. In 2006, less than 0.1 per cent of people living with HIV received TB preventive therapy.

48. Hepatitis B (HBV) and C (HCV) are also common co-infections among adults and children living with HIV. People living with HIV/HCV have a shorter life expectancy than people living with HIV alone, but if people living with HIV/HCV receive dual therapy their life expectancy improves.

3. The need to strengthen health systems

49. Acute shortages of health-care professionals impede the scale-up of HIV treatment and prevention services in many countries heavily affected by the epidemic. While there are 347 physicians for every 100,000 people in Norway, there are only 2 for every 100,000 people in Malawi or the United Republic of Tanzania. The human resource challenge in low- and middle-income countries has attracted considerable action and innovation in recent years, as manifested in new training and education initiatives, creative approaches to capacity-building and technical assistance, and task-shifting from doctors to nurses or medical officers in health-care settings in order to maximize the impact of limited professional capacity. Faith-based organizations, which provide a substantial share of HIV treatment and care in many countries, should be integrally involved in national efforts to expand antiretroviral access. As efforts increase to build additional human capacity in health-care settings, comparable work is needed to strengthen national capacity for drug regulation and the procurement and supply management of drugs and diagnostics. While working to strengthen health systems, countries and donors should also endeavour to build the capacity of community-based groups to help members of vulnerable populations get access to essential health and support services.

D. Structural determinants of risk and vulnerability

50. Although each case of sexual or drug-related HIV transmission results from individual behaviour, risk and vulnerability to HIV infection are also often subject to broad social forces beyond the control of individuals. Poverty, gender inequalities and the social marginalization suffered by groups most at risk make it difficult for individuals to reduce their risk or obtain essential HIV prevention, treatment, care

and support services. In addition to providing each individual with access to essential information and prevention commodities, efforts to curb the epidemic's spread must also address such structural factors, which increase the risk of HIV transmission.

1. Protecting and promoting the health of women and girls

51. Gender inequities fuel the continued spread of HIV, reducing women's ability to protect themselves from sexual transmission, increasing their vulnerability to sexual violence and placing them in circumstances where their risk of acquiring HIV is increased. Women now represent 61 per cent of HIV-infected adults in Africa, while infection levels among adolescent girls in Africa are several times higher than for boys their own age.

52. Globally, more than 80 per cent of countries, including 85 per cent in sub-Saharan Africa, have policies in place to ensure women's equal access to HIV prevention, treatment, care and support. In the case of antiretrovirals, countries have generally succeeded in ensuring access for women. The degree to which women-sensitive strategies have been implemented is unclear because, while most countries have strategic frameworks that address the epidemic's burden on women, only 53 per cent provide budgeted support for women-focused programmes.

53. Moreover, policies that provide for women's equal access to services are sometimes undermined by the lack of laws recognizing the right of women to own or inherit property. While such discriminatory legal frameworks have particular importance for women who are widowed as a result of HIV, they disempower all women and girls by increasing their financial dependence on men.

2. Grounding the AIDS response in human rights

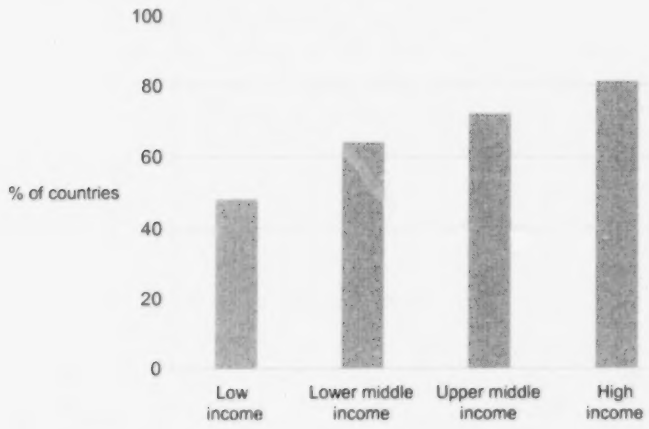
54. In the 2001 Declaration of Commitment on HIV/AIDS, Member States pledged to ground their national HIV responses in a broader human rights framework. That commitment involves more than a question of fairness. Because structural factors in many societies contribute to HIV risk and vulnerability, HIV prevention efforts will achieve their desired impact only if changes in individual risk behaviours are coupled with broader changes in society.

55. In 2001, Member States unanimously agreed to implement legal and policy frameworks to eliminate all forms of discrimination against people living with HIV. In 2007, two out of three countries reported having laws in place to protect people living with HIV from discrimination. The degree to which such anti-discrimination laws are enforced is unclear, and in some countries such favourable legal frameworks are being undermined by the increasing trend towards criminalization of HIV transmission.

56. The 2001 Declaration of Commitment on HIV/AIDS further recognized that the stigma and discrimination targeting populations most vulnerable to HIV also undermines the response to HIV. Seventy-three per cent of countries reported having non-discrimination laws or regulations that specify protections for vulnerable populations. Nevertheless, substantial barriers remain that reduce access to HIV prevention services: 63 per cent of countries report having policies that interfere with access of vulnerable populations to HIV-related services. As figure 10

illustrates, countries with higher incomes are more likely to have legal or regulatory barriers that reduce the access of key populations to HIV services.

Figure 10
Percentage of countries reporting laws, regulations or policies that impede HIV services for vulnerable populations, by income status



E. Addressing the needs of orphans and other children made vulnerable by AIDS

57. An estimated 12 million children under 18 have lost one or both parents to AIDS in sub-Saharan Africa. Surveys indicate that the number of households with persons newly infected by HIV is rapidly increasing in some of the most heavily affected countries in Southern Africa.

58. The 2001 Declaration of Commitment provided that countries would implement national strategies to strengthen the capacity of Governments, families and communities to support children orphaned and made vulnerable by HIV. Member States also pledged to protect orphans and other children from stigma or discrimination, and donors agreed to prioritize children-focused programming.

59. Thirty-three countries with generalized epidemics reported having a national strategy to address the needs of children orphaned or made vulnerable by HIV. However, many of those policies remain largely unimplemented. Among 11 high-prevalence countries with an adult HIV prevalence of 5 per cent or more where recent household surveys have been conducted, 15 per cent of orphans lived in households receiving some form of assistance, including medical care, school assistance, financial support or psychosocial services. That represents only a modest increase over the 10 per cent reported by high-prevalence countries in 2005.

60. Education is critical to children's future potential and sense of self-esteem and to the transmission of knowledge and values between generations within societies.

In 15 high-burden countries[5] where recent household survey data are available, orphans were on average 3 per cent less likely to attend school than non-orphans, suggesting that the gap in schooling between orphans and non-orphans seen earlier in the epidemic may be closing.

F. Humanitarian emergencies and post-conflict settings

61. The 2001 Declaration of Commitment stated that Governments and humanitarian actors should address HIV in post-conflict settings. Although efforts to implement HIV programmes in such settings encounter considerable challenges, significant progress has been made in improving access to services for displaced populations. Substantial additional work is required, however, because universal access to HIV prevention, treatment, care and support will not be achieved unless refugees and displaced populations are included in programmatic scale-up.

G. Mobilizing adequate financial resources

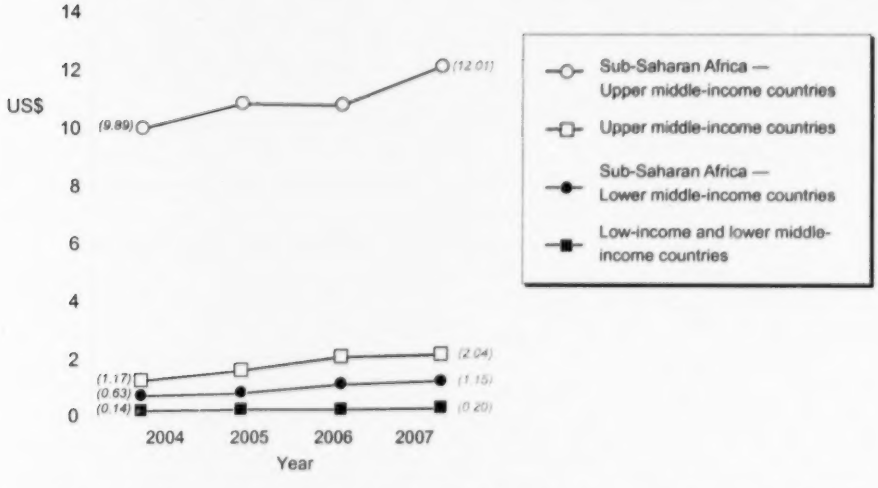
62. In 2001, Member States committed to mobilize between US$ 7 billion and US$ 10 billion for the AIDS response in low- and middle-income countries in 2005. That target was met in 2007.

63. Contributors to the growth in funding for HIV programmes in low- and middle-income countries were numerous. Created in direct response to the 2001 Declaration of Commitment, the Global Fund to Fight AIDS, Tuberculosis and Malaria had by March 2008 committed US$ 10.1 billion in multi-year funding for health programmes in 136 countries, with the majority of such funding dedicated to HIV initiatives. The United States President's Emergency Plan for AIDS Relief (PEPFAR) has provided more than US$ 15 billion in financial assistance for HIV prevention, treatment, care and support over the last five years, with the expectation that such assistance will increase further in the coming years. In 2006, the in-country disbursements from the Global Fund reached US$ 640 million and PEPFAR $2.1 billion. Philanthropic support for HIV activities in low- and middle-income countries nearly doubled between 2004 and 2006, reaching US$ 979 million.

64. Especially noteworthy are recent increases in expenditures by the countries most affected by HIV. In low-income and lower middle-income countries, per capita domestic spending on HIV more than doubled between 2005 and 2007 (figure 11). Per capita expenditure in low-income and lower middle-income countries continues to increase. Highest per capita expenditures were reported by five upper middle-income countries in sub-Saharan Africa, with spending projected to reach approximately US$ 12 per capita in those countries in 2007.

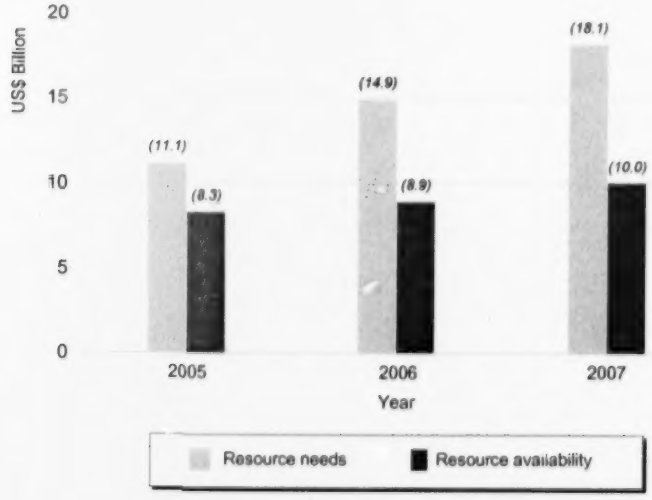
[5] Including Botswana, Cameroon, Central African Republic, Côte d'Ivoire, Gabon, Kenya, Lesotho, Malawi, Namibia, South Africa, Swaziland, Uganda, United Republic of Tanzania, Zambia and Zimbabwe.

Figure 11
Per capita HIV expenditures from domestic public sources in low- and middle-income countries, 2004-2007



65. Over time and following further analysis, it has become clear that the 2001 Declaration of Commitment on HIV/AIDS underestimated the financial resources that would be required to mount a comprehensive, evidence-informed response in low- and middle-income countries. As figure 12 indicates, despite the increase in annual resources available to low- and middle-income countries, the current pace of scale-up will not meet the estimated resources needed to achieve universal access to HIV prevention, treatment, care and support by 2010.

Figure 12
Funding gap between resource needs and resource availability, 2005-2007
(Billions of United States dollars)



V. Moving towards universal access to HIV prevention, treatment, care and support: recommendations for action

66. Two years away from the universal access targets and midway towards achieving the Millennium Development Goals, the world must build on its successes to accelerate the pace towards achieving universal access to HIV prevention, treatment, care and support. Unless the rate of scale-up increases, the world is unlikely to achieve such universal access by 2010. However, in a variety of countries, universal access may be achieved for specific sub-targets; for example, the Bahamas, Botswana and Thailand, among others, have already achieved 80 per cent (or universal) coverage for prevention of mother-to-child transmission. Similarly challenging is the Millennium Development Goals target of beginning to reverse national epidemics by 2015, as measured by a decrease in the percentage of young people who are HIV-positive. To successfully address those major challenges, urgent attention should be paid to the implementation of the recommendations set out below.

Leadership

67. **Strong, sustained political commitment and leadership must exist, involving all relevant sectors of society, civil society and people living with HIV, to build on recent successes and move more rapidly towards universal access to HIV prevention, treatment, care and support. True leadership is reflected in action, not words. In many countries, a gap exists between national strategic frameworks and their actual implementation. Where such gaps exist, they should be addressed and reduced. Similarly, the Governments of high-income countries must ensure universal access to HIV prevention, treatment, care and support, and must also provide substantially increased financial assistance to low- and middle-income countries to enable them to meet targets for universal access. Achieving and sustaining universal access to HIV prevention, treatment, care and support is the best means of ensuring that recent progress achieved by countries is maintained and can be extended to others.**

Ensuring the sustainability of the response to HIV

68. **To date, the response to HIV has been largely managed and viewed as an emergency effort. The HIV epidemic requires a sustained, long-term response in order to be overcome. The sustainability of the response must become central to all HIV-related planning and implementation. To that end, financing mechanisms need to be strong and durable over the long term and must be strengthened where they are weak or created where they are currently non-existent; unprecedented human resources must be mobilized in low- and middle-income countries; and, where required, critical new systems must be built and maintained to support a sustainable response. National leaders in affected countries, leaders of donor Governments, researchers, non-governmental organizations and all other stakeholders engaged in the response to HIV must plan for the long term.**

Scaling up comprehensive HIV prevention in hyper-endemic countries

69. **In countries where adult HIV prevalence is 15 per cent or greater, nothing short of a full-scale mobilization across society will successfully address the**

problems posed by HIV. However, in many such countries, young people remain poorly educated about HIV, coverage for basic HIV prevention services is far too low and few workplaces provide essential HIV prevention activities. Every available tool appropriate to national circumstances must be brought to scale, including population-wide campaigns on the risks associated with concurrent partnerships; energetic promotion of universal knowledge of HIV serostatus; adult male circumcision; prevention programmes focused on young people and populations most at risk; prevention activities in the workplace; and comprehensive services to prevent mother-to-child transmission. As treatment is scaled up, it should be closely linked with HIV prevention efforts.

Mounting an effective response to HIV in concentrated epidemics

70. Although overall HIV prevalence remains low in countries with concentrated epidemics, HIV is exacting an extraordinary toll on key subpopulations, including injecting drug users, men who have sex with men and sex workers. In some countries with concentrated epidemics, the existence of potential epidemiological "bridges" between populations most at risk and the general population poses the risk that the epidemic could become generalized in the absence of effective prevention measures. Scaling up focused HIV prevention strategies for populations most at risk represents an urgent public health necessity. HIV prevention coverage remains especially low for such groups, not because of the complexity of the task but primarily because of a lack of political will. National leaders must work to enact legislation and policies that protect and promote the human rights of populations most at risk of exposure to HIV; implement policies that improve service access; eliminate laws, policies and conditions that impede access to HIV prevention, treatment, care and support; and prioritize focused prevention programmes for populations most at risk. The recent report by the Commission on AIDS in Asia provides an excellent road map for building a strong and sustainable response to HIV in settings with low-level and concentrated epidemics.

Sustaining accelerated treatment scale-up while strengthening measures to address HIV/TB co-infection

71. While recent increases in treatment access represent a major achievement, the current pace of scale-up will not achieve universal access to treatment, resulting in millions of people living with HIV failing to obtain the life-preserving treatments they need. National Governments, donors and other stakeholders should work to quicken the pace of treatment scale-up. This will require continued increases in financial assistance for treatment scale-up; and the establishment and strengthening of strong national systems for procurement, supply management, drug regulation, quality assurance and training of health-care workers. Despite being mostly treatable and curable, tuberculosis remains one of the most common causes of illness and death in people living with HIV. While continuing and strengthening efforts to achieve universal access to antiretrovirals, countries should urgently undertake initiatives to improve the prevention, diagnosis and treatment of TB in order to reduce the unacceptable burden of TB among people living with HIV.

Addressing the role of gender inequities in deepening the HIV epidemic

72. **Because HIV is most often transmitted sexually, the unequal relationships between men and women, as well as gender stereotypes, fuel the spread of HIV. It is therefore vital that Governments incorporate massive political and social mobilization to address gender inequality and sexual norms within their national responses to HIV. Programmes must be grounded in a commitment to the protection of the human rights of girls and women, must seek to empower them to protect themselves from infection, and must meaningfully engage men as partners in the effort. National responses should ensure that women have access to the full range of sexual and reproductive health services, take action against gender-based violence, protect women's property and inheritance rights, and address the disproportionate burden of care experienced by women. Governments should ensure that gender is integrated into national action plans, that funding is identified and that national responses benefit from the full participation of women.**

Annex

Role of the United Nations in strengthening and supporting the HIV response

The Joint United Nations Programme on AIDS (UNAIDS) unites in a single biannual budget and workplan the HIV-related activities of 10 co-sponsors and the United Nations Secretariat pursuing HIV-related work in line with the UNAIDS Technical Support Division of Labour. Activities undertaken in 2007 include:

- The Office of the United Nations High Commissioner for Refugees (UNHCR), working closely with United Nations partners, Governments and non-governmental organizations, has provided technical and financial support to more than 70 countries. UNHCR has issued formal guidance on HIV in humanitarian and post-conflict settings, led inter-agency assessments of HIV programmes in such settings in 10 countries, and contributed to a significant increase in antiretroviral utilization among refugees and displaced populations.

- The United Nations Children's Fund (UNICEF) supports national scale-up of prevention of mother-to-child transmission of HIV; paediatric HIV diagnosis and treatment; protection, care and support for children affected by AIDS; and prevention of HIV transmission in adolescents in over 100 countries.

- The United Nations Development Programme (UNDP) supported more than 90 countries in addressing the links between HIV and development. UNDP and partners aided countries in strengthening HIV priorities in poverty reduction strategy papers and national development plans, and also facilitated national efforts to exercise flexibility in intellectual property agreements so as to increase access to essential medications. Together with the United Nations Development Fund for Women (UNIFEM) and the UNAIDS secretariat, UNDP convened a global consultation on gender and AIDS to develop gender guidance for national AIDS responses.

- The United Nations Educational, Scientific and Cultural Organization (UNESCO) leads the Global Initiative on HIV & AIDS, which in 2007 encompassed activities in 60 countries, including identification of national priority actions in 39 countries. UNESCO provided extensive technical support for HIV-related activities in education sectors throughout the world, including seven subregional capacity-building workshops in 2007.

- The United Nations Population Fund (UNFPA) supported 154 countries in expanding access to sexual and reproductive health services and supplies, including scaling up comprehensive condom programmes. The number of female condoms distributed increased from 13.9 million in 2005 to 25.9 million in 2007 and, in conjunction with UNHCR, UNFPA has brought more than 28 million male condoms and almost 300,000 female condoms to refugees in 23 countries.

- The United Nations Office on Drugs and Crime (UNODC) provided technical or financial support to at least 30 countries on HIV prevention and care among injecting drug users and prisoners. This included the development of a framework to assist countries in mounting effective national HIV strategies in prison settings, standards for treatment of drug dependence, and a technical

guide for countries to move towards universal access to HIV prevention, treatment, care and support for injecting drug users.

- The International Labour Organization (ILO) in 2007 provided technical support to Governments, employers and workers organizations in more than 70 countries, across all regions, in accordance with the principles established in the ILO Code of practice on HIV/AIDS and the world of work. The ILO network of peer educators works in 47 countries, and 28 countries in 2007 received ILO assistance in developing or revising laws and policies on HIV.

- The World Food Programme (WFP) reached more than 330,000 beneficiaries in 16 African countries with food support during the initiation of HIV treatment, as part of its support for HIV prevention, treatment, care and support in 50 countries. In 2007, WFP provided food support for programmes to prevent mother-to-child transmission in 14 countries, working closely with Governments, civil society groups and the UNAIDS family.

- The World Health Organization (WHO) encouraged the scale-up of HIV testing and counselling in health settings, collaborated with the UNAIDS secretariat to develop operational tools for the implementation of male circumcision services and supported population-based scale-up of programmes to prevent mother-to-child transmission. WHO has also assisted countries in estimating human resource needs and developing training, staff retention and task-shifting in line with national plans. First- and second-line treatment regimens for both adults and children have been simplified, and countries have been supported with global purchasing and procurement arrangements for second-line drugs.

- The World Bank funded national and regional HIV programmes, supported accelerated programme implementation, and helped strengthen monitoring and evaluation capacity in countries, in part through hands-on support for monitoring and evaluation activities in 56 countries through the Global HIV/AIDS Monitoring and Evaluation Team. Through the UNAIDS AIDS Strategy and Action Plan services, hosted by the World Bank, 39 countries received direct technical assistance to enhance national strategies and action plans.